

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain to the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3359

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03316

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>		c. LENGTH OF STAY IN 1b <u>9 wks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>31 Aberdeen</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>				d. STREET ADDRESS <u>1050 Storne Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Herr, etta</u> Middle <u>K</u> Last <u>Aaronson</u>				4. DATE OF DEATH Month <u>March</u> Day <u>29</u> Year <u>1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 21-1870</u>	
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel Morris</u>				14. MOTHER'S MAIDEN NAME <u>Henrietta Pittenhouse</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Russell T. Aaronson - 137 Aberdeen Rd. MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture L femur</u> 904.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell at home</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>2</u> p. m. <u>3-29-60</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Aberdeen Harford Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gerald C Palmer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, MD</u> DATE SIGNED <u>3-29-60</u>			
EXAMINER'S NAME (Type) <u>Gerald C Palmer, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/31/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bakers Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Aberdeen MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Harriug Aberdeen MD</u>				24a. REC'D BY REGISTRAR DATE <u>APR 1 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>	

3360

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>		c. LENGTH OF STAY IN lb <u>3 hrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>071 Hartford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Howard Samuel Adams</u>		4. DATE OF DEATH Month <u>March</u> Day <u>10</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 28, 1904</u>
9. AGE (In years last birthday) <u>55</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>machinist</u>	11. BIRTHPLACE (State or foreign country) <u>Iowa</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Albert Adams</u>	
14. MOTHER'S MAIDEN NAME <u>Minnie Reed</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>512-07-9844</u>		17. INFORMANT <u>Mrs. Howard S. Adams</u> Address <u>Bel Air, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Posterior Coronary Thrombosis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>A. S. C. V. D.</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>15 hrs.</u> <u>? 3 years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>3/10th</u> , 19 <u>60</u> , to <u>3/10th</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>3/10th</u> , 19 <u>60</u> , and that death occurred at <u>5:40 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward C. Loo</u> M.D.		DATE SIGNED <u>3/10/60</u>	
PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>		ADDRESS (Street, city or town, state) <u>Harre de Grace, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/14/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Mem. Gardens</u>	22d. LOCATION (City, town, or county) <u>Bel Air</u> (State) <u>MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles C. Kurtz</u> ADDRESS <u>Fairfetteville Md</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 14 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. ...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

STATE OF TEXAS

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3361

CERTIFICATE OF DEATH

03318

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE DE GRACE		c. LENGTH OF STAY IN 1b 6 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harford Md			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD Memorial Hosp.				d. STREET ADDRESS Franklin		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle FRANCIS Last BAKER				4. DATE OF DEATH Month MARCH Day 15 Year 19 60			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Oct. 6-1896	9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Commercial Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Self.		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME W.W. Baker				14. MOTHER'S MAIDEN NAME Susanna Thomas			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT James W. Baker Address R.D. 1 Elletts Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Occlusion (c) Arterio Sclerotic Heart Disease						INTERVAL BETWEEN ONSET AND DEATH 1 day 3 days 2	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from MARCH 9, 1960 , to MARCH 15, 1960 , that I last saw the deceased alive on MARCH 15, 1960 , and that death occurred at 11:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1000 N. Wadsworth Rd. Harford Md DATE SIGNED 3/16/60							
ACTUAL SIGNATURE Dr. H. Wadsworth				PHYSICIAN'S NAME (Type) Dr. H. Wadsworth			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 3/19/60		22c. NAME OF CEMETERY OR CREMATORY Wesley		22d. LOCATION (City, town, or county) (State) Cocke Hall, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Broughton Pm				24a. REC'D BY REGISTRAR DATE MAR 22 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1c 14 Film G258 3-9-60 et

3351

CERTIFICATE OF DEATH

03319

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		c. LENGTH OF STAY IN 1b <u>8 Years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>715 Ridgewood Rd</u>		1 d. STREET ADDRESS <u>715 Ridgewood Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>Edith</u> Middle <u>Marie</u> Last <u>Bradley</u>		4. DATE OF DEATH Month <u>March</u> Day <u>3</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 1 1898</u>
9. AGE (In years lost birthday) <u>61</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	11. BIRTHPLACE (State or foreign country) <u>Iowa</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Raymond Wheatley</u>	
14. MOTHER'S MAIDEN NAME <u>Anna Ryden</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Walter R. Bradley</u> Address <u>Bel Air Maryland.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic CV disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>2 years</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pneumonia Mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-1</u> , 19 <u>58</u> , to <u>3-3</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2-25</u> , 19 <u>60</u> , and that death occurred at <u>6 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		ADDRESS (Street, city or town, state) <u>Bel Air Md.</u> DATE SIGNED <u>3-3-60</u>	
PHYSICIAN'S NAME (Type) <u>Gerald C Palmer MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Mar. 7, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mountain Christian</u>	22d. LOCATION (City, town, or county) (State) <u>Joppa Harford Md.,</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard E. McKenna</u> ADDRESS <u>Abingdon Md</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 9 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Throckm</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES H. HARRIS		DATE OF DEATH JAN 10 1941	
AGE 68		SEX M	
RACE W		BIRTH DATE JAN 10 1872	
BIRTH PLACE BALTIMORE, MD		EDUCATION HIGH SCHOOL	
OCCUPATION LABORER		MARRIAGE MARRIED	
MARITAL STATUS MARRIED		SPOUSE'S NAME JANE HARRIS	
PLACE OF BIRTH BALTIMORE, MD		PLACE OF DEATH BALTIMORE, MD	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
DATE OF BURIAL JAN 12 1941		PLACE OF BURIAL BALTIMORE, MD	
SIGNATURE OF DECEASED JAMES H. HARRIS		SIGNATURE OF WITNESS JANE HARRIS	
SIGNATURE OF PHYSICIAN J. H. HARRIS		SIGNATURE OF CLERK J. H. HARRIS	

FOR STATE HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Items 18-21 Film 261
4-22-60
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3384 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03320

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Whiteford				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Whiteford			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Quarry Road				d. STREET ADDRESS Dooley Road			
3. NAME OF DECEASED (Type or print) MARY G. BROWN				4. DATE OF DEATH Month March Day 28 Year 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 17, 1914	
9. AGE (In years last birthday) 46 yrs.		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Harford Co., Md.		11. BIRTHPLACE (State or foreign country) USA	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Joseph E. Orr				14. MOTHER'S MAIDEN NAME Susie M. Heck			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No				16. SOCIAL SECURITY NO. 212-22-4398		17. INFORMANT Walter K. Brown, Whiteford, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cranio-cerebral Injury 8/2X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } DUE TO (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Struck by auto			
20c. TIME OF INJURY Month, Day, Year 12:30 p.m. 3/28/60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Road		20f. (City or town) (County) (State) Whiteford Harford Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>							
ACTUAL SIGNATURE Charles S. Petty				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Charles S. Petty, M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
				DATE SIGNED 3/29/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Mar. 31, 1960		22c. NAME OF CEMETERY OR CREMATORY Slate Ridge	
				22d. LOCATION (City, town, or country) (State) Delta, York Co., Penna.			
23. FUNERAL DIRECTOR John H. Markins				ADDRESS Delta, Penna.		24a. REC'D BY REGISTRAR MAR 31 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Knaus			

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INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in, by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03321

3352

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Harford</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>BEL AIR</u>		LENGTH OF STAY (in this place) <u>LIFE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Forest Hill</u>			
TOWN <u>BEL AIR</u>				TOWN <u>Rural Forest Hill</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>ADY ROAD</u>				STREET ADDRESS (If rural give location) <u>Ady Road</u>			
3. NAME OF DECEASED (Type or Print) <u>Mary F. Bull</u>				4. DATE OF DEATH (Month) <u>March</u> (Day) <u>8</u> (Year) <u>1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>FEB. 23, 1885</u>	
				9. AGE last birthday <u>75</u> yrs.		10. IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>		11. BIRTHPLACE (State or foreign country) <u>Harford Co, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>R.D. #2 Charles E. Bull Forest Hill, Md.</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
260 IMMEDIATE CAUSE (A) <u>CONGESTIVE HEART FAILURE</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 HOURS</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>CORONARY OCCLUSION</u>						<u>5 DAYS</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>DIABETES MELLITUS</u>						<u>10 YEARS</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>BRONCHIAL ASTHMA</u>						<u>6 YEARS</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/8/1955</u> , to <u>3/8/1960</u> , that I last saw the deceased alive on <u>3/8/1960</u> , and that death occurred at <u>12:38 PM</u> from the causes and on the date stated above.							
SIGNATURE <u>Robert Barthel</u>				ADDRESS (Street, city, town, state) <u>Forest Hill, Md.</u>		DATE SIGNED <u>3/9/60</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>Mar 11, 1960</u>		NAME OF CEMETERY OR CREMATORY <u>DEER CREEK Methodist Cemetery</u>		LOCATION (City, town, or county) <u>Forest Hill RD, Harford Co, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Arthur L. Knecht</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Foster</u>		ADDRESS <u>W. Broadway + Williams St. Bel Air, Maryland</u>	
DATE <u>MAR 10 '60</u>							

For each person as shown on the list, the following information should be furnished: Name, sex, age, date of birth, date of death, place of birth, place of death, cause of death, and other pertinent information. This information should be furnished in the following order: Name, sex, age, date of birth, date of death, place of birth, place of death, cause of death, and other pertinent information.

CERTIFICATE OF DEATH

3332

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

Reg. No. 114

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. DATE OF DEATH		6. PLACE OF BIRTH		7. PLACE OF DEATH		8. CAUSE OF DEATH		9. OTHER INFORMATION	
JAMES H. HARRIS		Male		45		10/15/1875		10/20/1920		Baltimore, Md.		Baltimore, Md.		Heart Disease		None	
10. MARITAL STATUS		11. OCCUPATION		12. EDUCATION		13. RELIGION		14. RACE		15. COLOR		16. SEX		17. AGE		18. DATE OF BIRTH	
Married		None		High School		Protestant		White		White		Male		45		10/15/1875	
19. DATE OF DEATH		20. PLACE OF DEATH		21. CAUSE OF DEATH		22. OTHER INFORMATION		23. SIGNATURE		24. DATE		25. PLACE		26. NAME		27. TITLE	
10/20/1920		Baltimore, Md.		Heart Disease		None		J. H. Harris		10/20/1920		Baltimore, Md.		J. H. Harris		Registrar	

CERTIFICATE OF DEATH

Reg. Dist. No.

13322

3362

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>URICE DE GRACE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X FALLSTON</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL Hosp.</u>				d. STREET ADDRESS <u>RD 2 ; Box 109</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WARD</u> <u>PRESTON</u> <u>CARMAN</u>				4. DATE OF DEATH Month Day Year <u>MARCH</u> <u>12</u> <u>1960</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/25/95</u>	9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Yardmaster (Ret)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Lewis Carman</u>				14. MOTHER'S MAIDEN NAME <u>Sarah J. Crompton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>XXXXXXXXXX</u>		17. INFORMANT <u>Mrs. Ward P. Carman</u>		Address <u>Rd. 2, Box 109</u> <u>Fallston, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>multiple Sclerotic</u> 345X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Decubitus</u> <u>ulcers</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/19</u> , 19 <u>60</u> , to <u>3/12</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>3/12</u> , 19 <u>60</u> , and that death occurred at <u>12:10 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward C. Tarrington</u> M.D.				ADDRESS (Street, city or town, state) <u>211 N. Union Ave.</u> DATE SIGNED <u>3/12/60</u>			
PHYSICIAN'S NAME (Type) <u>Edward C. Tarrington</u>				ADDRESS <u>Harre de Grace Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/15/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Ignatius Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hickory, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Tarrington</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 15 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

be retained by the hospital or attending physician.

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. The first part of the document is a letter from the author to the editor, dated 10/10/1964. The letter discusses the author's interest in the topic of the journal and the importance of the research. The author mentions that the research was conducted in a laboratory setting and that the results are preliminary. The author also mentions that the research was funded by the National Science Foundation.

3363

CERTIFICATE OF DEATH

64565

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>HARford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>HARford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAUSE de GRACE</u>		c. LENGTH OF STAY IN 1b <u>4 days 31</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address), OR INSTITUTION <u>071 HARford mem. Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Susan</u> Middle <u>Adelaide</u> Last <u>Carver</u>		4. DATE OF DEATH Month <u>March</u> Day <u>31</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>18 July 1898</u>
9. AGE (In years last birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	11. IF UNDER 24 HRS. Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>N. Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Alfred S. Whittenore (deceased)</u>		14. MOTHER'S MAIDEN NAME <u>Cordie Simmons (deceased)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-30-3833</u>	
17. INFORMANT <u>Thos. C. Carver Jr.</u>		Address <u>Snow Hill, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of Body of Uterus</u> DUE TO (b) <u>Abdominal Carcinomatosis</u> DUE TO (c) <u>Cachexia</u> 172X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 yrs.</u> <u>3 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on <u>March 31</u> , 19 <u>60</u> , and that death occurred at <u>9:55</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. H. Sadowsky</u>		DATE SIGNED <u>3/31/60</u>	
PHYSICIAN'S NAME (Type) <u>W. H. Sadowsky, M.D.</u>		ADDRESS (Street, city or town, state) <u>507 Penn St. Harford, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/2/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Bakers Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>R.D. Aberdeen, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Tarring</u>		24a. REC'D BY REGISTRAR <u>APR 5 '60</u>	
ADDRESS <u>Tarring Funeral Home Aberdeen, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF ARIZONA

• 1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840.

3364
CERTIFICATE OF DEATH

Reg. Dist. No.

03323

1. PLACE OF DEATH a. COUNTY MARYLAND HARFORD				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HARFORD				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 31 Aberdeen,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL Hospital				d. STREET ADDRESS 116 Osborne Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last THOMAS C CARVER				4. DATE OF DEATH Month Day Year MARCH 14 1960			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/28/96	
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Master Machinist				10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME James Howard Carver				14. MOTHER'S MAIDEN NAME Florence Vanters			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Cardiac Decompensation, acute 3 days				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 260x Kimmelstiel-Wilson's Disease DUE TO (b) Diabetes mellitus and A.S.C.V.D. DUE TO (c) and H.C.V.D. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				INTERVAL BETWEEN ONSET AND DEATH 12-13 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office-bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 3/8/60 , 19 60 , to 3/14th , 19 60 , that I last saw the deceased alive on 3/14th , 19 60 , and that death occurred at 7:30 P. M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE Edward C. Loo, M.D.				ADDRESS 211 N. Union Ave.			
PHYSICIAN'S NAME (Type) Edward C. Loo, M.D.				ADDRESS Harford, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/17/60		22c. NAME OF CEMETERY OR CREMATORY Bakers Cemetery		22d. LOCATION (City, town, or county) (State) R.D. 2, Aberdeen, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John Tarring				24. REC'D BY REGISTRAR DATE MAR 21 '60		24b. REGISTRAR'S SIGNATURE Charles S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE OF DEATH _____		COUNTY OF _____ STATE OF _____	
NAME OF DECEASED _____		SEX _____ AGE _____	
DATE OF DEATH _____		TIME OF DEATH _____	
PLACE OF BIRTH _____		DATE OF BIRTH _____	
OCCUPATION _____		CAUSE OF DEATH _____	
MEDICAL HISTORY _____		PATHOLOGICAL HISTORY _____	
SIGNATURE OF PHYSICIAN _____		SIGNATURE OF CORONER _____	
SIGNATURE OF WITNESS _____		SIGNATURE OF JURY _____	
SIGNATURE OF DECEASED _____		SIGNATURE OF SURVIVOR _____	
SIGNATURE OF FUNERAL HOME _____		SIGNATURE OF BURIAL SOCIETY _____	
SIGNATURE OF CHURCH _____		SIGNATURE OF CEMETERY _____	
SIGNATURE OF MARRIAGE OFFICE _____		SIGNATURE OF PROBATE COURT _____	
SIGNATURE OF COUNTY CLERK _____		SIGNATURE OF STATE DEPARTMENT OF HEALTH _____	

REGISTERED COPY
 BALTIMORE, MARYLAND
 DEPARTMENT OF HEALTH
 18

3365

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAUPPE DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>1 day 15 hrs 33 min</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BELAIR 32</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSP</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Boy</u> Last <u>CATRON</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>2</u> Year <u>1960</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 1, 1960</u>	
9. AGE (In years last birthday) <u>1</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>5</u> Hours <u>32</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>USA-Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Ed Catron</u>				14. MOTHER'S MAIDEN NAME <u>Peggy Spicer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Edward Catron Bel Air, R.D., Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>776 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 1, 1960</u> , to <u>March 2 1960</u> , that I lost sows the deceased alive on <u>March 2</u> , 19 <u>60</u> , and that death occurred at <u>5:40 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Erlinda L. Maribella, M.D.</u>				PHYSICIAN'S NAME (Type) <u>ERLINDA L. MARIBELLA</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar. 6, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove</u>		22d. LOCATION (City, town, or county) (State) <u>Bel Air Harford Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. McKenna</u>				ADDRESS <u>Abingdon, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 9 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2071332XVI

3385

CERTIFICATE OF DEATH

03325

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Joppa</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Joppa</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Jennie</u> First <u>Marie</u> Middle <u>Dorman</u> Last		4. DATE OF DEATH <u>March</u> Month <u>23</u> Day <u>19</u> Year <u>60</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 15, 1895</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Servant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.,</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.,</u>	
13. FATHER'S NAME <u>William Trimble</u>		14. MOTHER'S MAIDEN NAME <u>Alice Brown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Charles Dorman</u> Address <u>Bradshaw Maryland.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetes</u> <u>260 x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>14 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 19, 1960</u> , to <u>March 23, 1960</u> , that I last saw the deceased alive on <u>March 22, 1960</u> , and that death occurred at <u>4 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William A. Tyson</u> M.D.		ADDRESS (Street, city or town, state) <u>Kingsville, Md.</u> DATE SIGNED <u>3-23-60</u>	
PHYSICIAN'S NAME (Type) <u>William A. Tyson</u>		<u>Kingsville Maryland.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Mar. 26, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Asbury</u>	22d. LOCATION (City, town, or county) (State) <u>Loreley, Balto., Md.,</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard R. McCombs</u> ADDRESS <u>Abingdon, Md.,</u>		24a. REC'D BY REGISTRAR <u>MAR 29 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of the certificate is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3366

Item 14, Film

Film 6259 3/21/60 1b

03326

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE MD b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE DE GRACE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 24 HAURE DE GRACE			
c. LENGTH OF STAY IN 1b 10 DAYS				d. STREET ADDRESS 480 N Union Ave			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Alfred A Middle Duchette Last Duchette				4. DATE OF DEATH Month MARCH Day 14 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 5 - 1902	
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months 5 Days 7 Hours 57 Min.		IF UNDER 24 HRS. Months 5 Days 7 Hours 57 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY —			
11. BIRTHPLACE (State or foreign country) HAUTE Canada				12. CITIZEN OF WHAT COUNTRY? US			
13. FATHER'S NAME Alfred MORIN				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adams - Stokes Disease 433.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Anteroseptal infarction DUE TO (c) A. S. C. V. D. INTERVAL BETWEEN ONSET AND DEATH 2 days 10 days 3-4 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypostatic Pneumonia							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month March Day 4 Year 1960 Hour o. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from MARCH 4, 1960 , to MARCH 4th 1960 , that I last saw the deceased alive on MARCH 14, 1960 , and that death occurred at 2:30 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Edward C. Loo M.D.				ADDRESS (Street, city or town, state) 211 N. Union Ave.			
DATE SIGNED 3/14/60							
PHYSICIAN'S NAME (Type) Edward C. Loo, M.D. Haure de Grace, Md.							
22a. BURIAL CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 3/17/60		22c. NAME OF CEMETERY OR CREMATORY Bellin Mem. Garden		22d. LOCATION (City, town, or county) (State) Bellin MD	
23. FUNERAL DIRECTOR'S SIGNATURE William R. Hamel ADDRESS Hamlet, Md.				24a. REC'D BY REGISTRAR DATE MAR 17 '60			
24b. REGISTRAR'S SIGNATURE Arthur S. Kraw							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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3367

CERTIFICATE OF DEATH

03327

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>HARTFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>HARTFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVERDE GRACE, MD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>31 Aberdeen</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>071 Hartford Memorial Hospital</u>		d. STREET ADDRESS <u>165 Mt. Royal Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Delia</u> Middle <u>Eustace</u> Last <u>Eustace</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>10</u> Year <u>1960</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 10, 1875</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Carey</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		17. INFORMANT <u>Francis Eustace (son)</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma sigmoid colon</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 2, 1960</u> , to <u>March 10, 1960</u> , that I last saw the deceased alive on <u>March 9, 1960</u> , and that death occurred at <u>11:09 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James McC. Finney</u>		ADDRESS (Street, city or town, state) <u>524 Lewis St., Haverde Grace Maryland</u>	
PHYSICIAN'S NAME (Type) <u>James McC. Finney M.D.</u>		DATE SIGNED <u>3-10-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/14/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Francis Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Abingdon, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Tarring</u> ADDRESS <u>Funeral Home Aberdeen, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 14 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3368

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAUREDE GRAVE				c. LENGTH OF STAY IN 1b 31			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 071 HARFORD MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last JOSEPH GORDON GRACE				4. DATE OF DEATH Month Day Year MARCH 22 1960			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 14, 1891	9. AGE (In years last birthday) yrs. 68	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Com. Artist & Engr.		10b. KIND OF BUSINESS OR INDUSTRY Engraving Business		11. BIRTHPLACE (State or foreign country) XXXXXXX Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Francis Joseph Grace				14. MOTHER'S MAIDEN NAME Eva L. Anderson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 089-07-7908		INFORMANT Address 134 Beach Ct. Mary J. Grace, Aberdeen, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus						INTERVAL BETWEEN ONSET AND DEATH sudden 15 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 1st, 1959 to March 22, 1960 that I last saw the deceased alive on March 22nd, 1960 and that death occurred at 6:02 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Edward C. Loo, M.D.				ADDRESS (Street, city or town, state) 211 N. Union Ave.		DATE SIGNED 3/22/60	
PHYSICIAN'S NAME (Type) Edward C. Loo, M.D.				Havre de Grace, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 3/23/60		22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery		22d. LOCATION (City, town, or county) (State) Richmond, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE John E. Tarring				Tarring Funeral Home Aberdeen, Md.		24a. REC'D BY REGISTRAR MAR 25 1960	
24b. REGISTRAR'S SIGNATURE Arthur S. Evans				DATE			

10732

CERTIFICATE OF DEATH

1912

Deceased

Abraham

130 Beach Court

Aug. 11, 1891

1139

Eve M. Anderson

Virginia Joseph Green

130 Beach Court

000-07-7900 Mary J. Green, Anderson, Maryland

CERTIFICATE OF DEATH

Reg. Dist. No.

03329

3353

1. PLACE OF DEATH a. COUNTY <u>Bel Air Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>	c. LENGTH OF STAY IN 1b <u>36 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Bel Air, Toll Gate Rd.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Convalescing Home</u>		d. STREET ADDRESS <u>Harford Convalescing Home</u> (Residence) e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Amicus Greene</u> First Middle Last		4. DATE OF DEATH <u>March 29</u> Month Day Year <u>19 60</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 31, 1877</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMER</u>	11. BIRTHPLACE (State or foreign country) <u>Boone N.C.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Solomon GREENE</u>	
14. MOTHER'S MAIDEN NAME <u>Sarah GREENE</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes, give war & dates of service) <u>✓</u>	
16. SOCIAL SECURITY NO. <u>✓</u>		17. INFORMANT <u>Fred Greene Jarrettsville MD</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic CV disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3-28</u> , 19 <u>60</u> , to <u>3-28</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>3-28</u> , 19 <u>60</u> , and that death occurred at <u>9:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		ADDRESS (Street, city or town, state) <u>Bel Air, MD</u> DATE SIGNED <u>3-29-60</u>	
PHYSICIAN'S NAME (Type) <u>Gerald C Palmer MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>April 1, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Fountain Green, Bel Air R.D., Harf Co., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Foster</u> ADDRESS <u>W. Broadway + Williams St. Bel Air, Maryland</u>		24a. REC'D BY REGISTRAR <u>MAR 31 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3369

Item 1, Film G250 3/27/60 1b

CERTIFICATE OF DEATH

03330

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAUPE DE GRACE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Belcamp</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>enroute to Harford Memorial Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>JAMES B</u> First Middle Last				4. DATE OF DEATH <u>MARCH 8</u> 19 <u>60</u> Month Day Year			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar. 6, 1902</u>	
9. AGE (In years last birthday) <u>58</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Operating Engineer</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Amos Gross</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE BAEK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>220-20-7898</u>		17. INFORMANT Address <u>Mrs., Ethel Gross, Belcamp Maryland.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Coronary Atherosclerosis</u> (c) <u>?</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>2 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cholesterol blood</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>April, 1958</u> to <u>March, 1960</u> , that I last saw the deceased alive on <u>March 5, 1960</u> , and that death occurred at <u>9:05 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J Ralph Horke</u> M.D.				ADDRESS (Street, city or town, state) <u>Churchville Md</u> DATE SIGNED <u>March 8, 1960</u>			
PHYSICIAN'S NAME (Type) <u>J Ralph Horke MD</u>				Churchville Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar. 11, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Trinity Lutheran</u>		22d. LOCATION (City, town, or county) (State) <u>Joppa Harford Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. Jones</u> ADDRESS <u>Abingdon Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 14 1960</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH 12-5-29		5. PLACE OF BIRTH MOBILE, ALA.	
6. OCCUPATION None		7. MARITAL STATUS Single		8. COLOR White		9. RELIGION None		10. EDUCATION High School	
11. CAUSE OF DEATH Suicide		12. MANNER OF DEATH Homicide		13. PLACE OF DEATH Baltimore, Md.		14. TIME OF DEATH 11:00 AM		15. DATE OF DEATH 6-4-68	
16. SIGNATURE OF PHYSICIAN J. Edgar Hoover		17. SIGNATURE OF CORONER J. Edgar Hoover		18. SIGNATURE OF WITNESS J. Edgar Hoover		19. SIGNATURE OF DECEASED J. Edgar Hoover		20. SIGNATURE OF NEXT OF KIN J. Edgar Hoover	
21. SIGNATURE OF REGISTRAR J. Edgar Hoover		22. SIGNATURE OF CLERK J. Edgar Hoover		23. SIGNATURE OF CHIEF OF BUREAU J. Edgar Hoover		24. SIGNATURE OF ASSISTANT CHIEF OF BUREAU J. Edgar Hoover		25. SIGNATURE OF DEPUTY CHIEF OF BUREAU J. Edgar Hoover	

1. This is a true and correct copy of the original certificate of death as filed in the office of the Registrar of Deaths, Baltimore, Maryland, on June 4, 1968.

2. This is a true and correct copy of the original certificate of death as filed in the office of the Registrar of Deaths, Baltimore, Maryland, on June 4, 1968.

3. This is a true and correct copy of the original certificate of death as filed in the office of the Registrar of Deaths, Baltimore, Maryland, on June 4, 1968.

4. This is a true and correct copy of the original certificate of death as filed in the office of the Registrar of Deaths, Baltimore, Maryland, on June 4, 1968.

5. This is a true and correct copy of the original certificate of death as filed in the office of the Registrar of Deaths, Baltimore, Maryland, on June 4, 1968.

6. This is a true and correct copy of the original certificate of death as filed in the office of the Registrar of Deaths, Baltimore, Maryland, on June 4, 1968.

7. This is a true and correct copy of the original certificate of death as filed in the office of the Registrar of Deaths, Baltimore, Maryland, on June 4, 1968.

8. This is a true and correct copy of the original certificate of death as filed in the office of the Registrar of Deaths, Baltimore, Maryland, on June 4, 1968.

9. This is a true and correct copy of the original certificate of death as filed in the office of the Registrar of Deaths, Baltimore, Maryland, on June 4, 1968.

10. This is a true and correct copy of the original certificate of death as filed in the office of the Registrar of Deaths, Baltimore, Maryland, on June 4, 1968.

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INSTRUCTIONS

TO THE ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3370

CERTIFICATE OF DEATH

03331

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARTFORD</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>HARTFORD</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>HAVRE DE GRACE</u>		LENGTH OF STAY (in this place) <u>LIFE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>HAVRE DE GRACE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>REVOLUTION ST</u>				STREET ADDRESS (If rural give location) <u>1 REVOLUTION ST</u>			
3. NAME OF DECEASED (Type or Print) (First) <u>JOHN</u> (Middle) <u>WESLEY</u> (Last) <u>HEMORE</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>MAR 22</u> , 19 <u>60</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>BLACK</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>APR. 1 1876</u>	9. AGE last birthday <u>83</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>JOHN W. HEMORE SR.</u>				14. MOTHER'S MAIDEN NAME <u>HARRIETT STANSBURY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-12-9496</u>		17. INFORMANT & ADDRESS <u>Vernon Stansbury, Havre de Grace Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
443X IMMEDIATE CAUSE (A) <u>Congestive Heart Failure</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cerebral Thrombosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Hypertensive - Arteriosclerotic Heart disease</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/23</u> , 19 <u>59</u> , to <u>3/21</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>3/18</u> , 19 <u>60</u> , and that death occurred at <u>9:00 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>George J. Stansbury</u>				ADDRESS (Street, city, town, state) <u>M.D. 569 Revolution St. Havre de Grace, Md.</u>		DATE SIGNED <u>3/21/60</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>MAR 23 1960</u>		NAME OF CEMETERY OR CREMATORY <u>ST. JAMES</u>		LOCATION (City, town, or county) (State) <u>HAVRE DE GRACE, MD</u>	
24. REC'D BY REGISTRAR <u>DATE MAR 24 '60</u>		REGISTRAR'S SIGNATURE <u>John S. Kline</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mitchell</u> ADDRESS <u>Havre de Grace Md.</u>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3386 CERTIFICATE OF DEATH

Reg. Dist. No.

03332

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Black Horse				c. LENGTH OF STAY IN 1b 82 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mary Corrine Henderson				4. DATE OF DEATH Mar. 5 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 12, 1877	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Black Horse, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William F. Henderson				14. MOTHER'S MAIDEN NAME Elizabeth Webb			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) 6----		16. SOCIAL SECURITY NO. -----		17. INFORMANT Ross C. Henderson Address White Hall, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio sclerotic cardio vascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1945 , to Mar. 5 1960 , that I last saw the deceased alive on Mar. 4 1960 , and that death occurred at 7 a.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Parkton, Md. DATE SIGNED 3/5/60							
ACTUAL SIGNATURE A. M. France M.D. Parkton, Md.							
PHYSICIAN'S NAME (Type) A. M. France							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/8/1960		22c. NAME OF CEMETERY OR CREMATORY Mc Kendree		22d. LOCATION (City, town, or county) (State) Black Horse Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Gunt				ADDRESS Jarrettsville Md.		24a. REC'D BY REGISTRAR Mar 10 '60	
				24b. REGISTRAR'S SIGNATURE Charles E. Gunt			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3387

CERTIFICATE OF DEATH

Reg. Dist. No.

64575

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen R.D.</u>				c. LENGTH OF STAY IN 1b <u>37 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Calvary</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Albert</u> Middle <u>P.</u> Last <u>Hoffman</u>				4. DATE OF DEATH Month <u>Mar.</u> Day <u>29</u> Year <u>19 60</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 27, 1886</u>		9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Owner</u>		11. BIRTHPLACE (State or foreign country) <u>Harford Co., Md.,</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.,</u>	
13. FATHER'S NAME <u>Abraham Hoffman</u>				14. MOTHER'S MAIDEN NAME <u>Andora Wildason</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-14-6395</u>		17. INFORMANT Address <u>Mrs. Effie A. Hoffman (Aberdeen Md.,</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio Sclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month _____ Day _____ Year <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>3/25</u> , 19 <u>56</u> , to <u>3-29-60</u> , that I last saw the deceased alive on <u>3/25</u> , 19 <u>60</u> , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>A.L. Lewis</u> M.D.				214 Union Ave, Havre de Grace, Maryland.			
PHYSICIAN'S NAME (Type) <u>A.L. Lewis</u>				214 Union Ave, Havre de Grace, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr. 1, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Calvary Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Calvary, Harford, Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard R. McCombs Jr</u>				ADDRESS <u>Abingdon, Md.,</u>		24a. REC'D BY REGISTRAR DATE <u>APR 5 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinner</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ELWIN BOND

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

Name of Deceased		Sex		Age	
John Doe		Male		45	
Date of Death		Place of Death		Cause of Death	
1950-01-15		Home		Heart Disease	
Time of Death		Occupation		Manner of Death	
10:00 AM		Teacher		Natural	
Signature of Physician		Signature of Registrar		Signature of Informant	
[Signature]		[Signature]		[Signature]	
Name of Informant		Relationship		Address	
John Doe		Son		123 Main St, Baltimore, MD	
Name of Physician		Address		Telephone	
Dr. Smith		456 Oak St, Baltimore, MD		555-1234	
Name of Hospital		Address		Telephone	
St. Mary's Hospital		789 Pine St, Baltimore, MD		555-5678	
Name of Burial Place		Address		Telephone	
Greenwood Cemetery		101 Elm St, Baltimore, MD		555-9012	
Name of Undertaker		Address		Telephone	
ABC Undertaking Co.		202 Cedar St, Baltimore, MD		555-3456	
Name of Registrar		Address		Telephone	
Maryland State Department of Health		300 North Enoch Ave, Baltimore, MD		555-7890	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed with the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the health officer prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3398 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03333

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Aberdeen Proving Grounds</u>		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>James W. Hornberger Jr</u>		4. DATE OF DEATH <u>March 22 1960</u>	
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-23-21</u>	
9. AGE (In years last birthday) <u>39</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Eng. Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Aberdeen Proving Grounds</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Walter Hornberger</u>		14. MOTHER'S MAIDEN NAME <u>Mae Chamberlain</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>World War 2</u>		16. SOCIAL SECURITY NO. <u>219-03-7769</u>	
17. INFORMANT <u>Helen Bailey Hornberger</u>		Address <u>Perryville, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage & radial artery</u> 977X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Cut wrist with razor</u>	
20c. TIME OF INJURY Month, Day, Year <u>10 a.m. 3-22-60</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>A.P.G. Aberdeen</u>		20f. (City or town) <u>Harford</u> (County) <u>MD</u> (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Boyer, W</u> DATE SIGNED <u>3-22-60</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-26-1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Asbury Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Port Deposit, Md. Rural</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Veera Patterson & Son</u>		ADDRESS <u>Perryville, Md</u>	
24a. REC'D BY REGISTRAR <u>MAR 28 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Christina L. Hunt</u>	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Name]</p>		<p>2. SEX [Male/Female]</p>	
<p>3. DATE OF BIRTH [Date]</p>		<p>4. PLACE OF BIRTH [Place]</p>	
<p>5. OCCUPATION [Occupation]</p>		<p>6. MARITAL STATUS [Single/Married/Widowed]</p>	
<p>7. STREET ADDRESS [Address]</p>		<p>8. CITY AND STATE [City, State]</p>	
<p>9. DATE OF DEATH [Date]</p>		<p>10. TIME OF DEATH [Time]</p>	
<p>11. PLACE OF DEATH [Place]</p>		<p>12. CAUSE OF DEATH [Cause]</p>	
<p>13. MANNER OF DEATH [Manner]</p>		<p>14. SIGNATURE OF EXAMINER [Signature]</p>	
<p>15. DATE OF EXAMINATION [Date]</p>		<p>16. SIGNATURE OF WITNESS [Signature]</p>	

3354

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air				c. LENGTH OF STAY IN 1b 1 week			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Convalescent Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lucy Middle B. Last Hudson				4. DATE OF DEATH Month March Day 15 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 26, 1863	
9. AGE (In years last birthday) 96 yrs.		10. IF UNDER 1 YEAR Months 05 Days X Hours 2 Min.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY —			
13. FATHER'S NAME Lamar Reed				14. MOTHER'S MAIDEN NAME Martha Ward			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Harford Convalescent Home, Bel Air, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Cardio-vascular Disease DUE TO (c) ?							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ? 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from March 7, 1960 , to March 15, 1960 , that I last saw the deceased alive on March 15, 1960 , and that death occurred at 7:10a. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Forest Hill, Md. DATE SIGNED March 15, 1960							
ACTUAL SIGNATURE Willard P. Hudson M.D.				PHYSICIAN'S NAME (Type) Willard P. Hudson, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		3-17-60		Greensboro		Greensboro, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. E. Boulais				24a. REC'D BY REGISTRAR MAR 17 '60			
ADDRESS Greensboro, Md.				24b. REGISTRAR'S SIGNATURE Arthur L. Frank			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE AND STATE DEPARTMENT OF HEALTH—BALTIMORE, 12

3371

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harps de Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Deposit</u> 07X-2	
3. NAME OF DECEASED (Type or print) <u>Eva Myrtle Jackson</u>		d. STREET ADDRESS	
4. DATE OF DEATH <u>March 20 1960</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 26, 1891</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Samuel Jackson</u>		14. MOTHER'S MAIDEN NAME <u>Mary Batters</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-36-8134</u>	
17. INFORMANT <u>Margaret Jackson - daughter-in-law</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> 572.1 DUE TO Circumstances, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Dissecting aortic aneurysm</u> DUE TO <u>old atherosclerosis</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u> <u>6 wks.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-20-60</u> to <u>3-20-60</u> , that I last saw the deceased alive on <u>3-20-60</u> , and that death occurred at <u>1:00 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wm. K. Brendle</u> M.D.		ADDRESS (Street, city or town, state) <u>Harps de Grace</u> DATE SIGNED <u>3-20-60</u>	
PHYSICIAN'S NAME (Type) <u>Wm. K. Brendle</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-23-1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Asbury Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Port Deposit, Md. Rural</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee A. Patterson & Son</u> ADDRESS <u>Perryville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 23 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Wm. K. Brendle</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WEST VIRGINIA DEPT. OF HEALTH

1931

July 26, 1931

Dr. J. H. ...

... ..

3372

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Hartford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hartford-de-Grace</u>				c. LENGTH OF STAY IN 1b <u>5 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ida</u> Middle <u>Smith-Jacobs</u> Last <u>Smith-Jacobs</u>				4. DATE OF DEATH Month <u>March</u> Day <u>24</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-29-78</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Bernard Leopold</u>				14. MOTHER'S MAIDEN NAME <u>Rieka Emerich</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>Box 141-R.D.#2</u>		17. INFORMANT Address <u>Box 141-R.D.#2 Bel Air Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal Obstruction</u> <u>570.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypostatic Pneumonia</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/19</u> , 19 <u>60</u> , to <u>3/24</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>3/24</u> , 19 <u>60</u> , and that death occurred at <u>6 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Box 966 Edgewood, Md</u> DATE SIGNED <u>3/24/60</u>							
ACTUAL SIGNATURE <u>E. Louis Kahan</u>		PHYSICIAN'S NAME (Type) <u>E. Louis Kahan</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>March 25/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Maimonides</u>		22d. LOCATION (City, town, or county) (State) <u>Brooklyn, New York</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Sol. Levinson & Bros. Inc. 6010 Reist Rd</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 28 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Kahan</u>	

1
VS A15 (4)
15M 10/57

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 13, 14, Film G259 3/23/60 1b

CERTIFICATE OF DEATH

03337

3355

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air		c. LENGTH OF STAY IN 1b 10 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford County Home, Toll Gate Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Thomas Middle Jones Last Jones		4. DATE OF DEATH Month March Day 13 Year 19 60	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 5, 1872
9. AGE (In years lost birthday) 87 yrs.		10. BIRTHPLACE (State or foreign country) Maryland	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Clark E. Fitzpatrick, Bel Air, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic malignant melanoma original site: heel DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) of the right foot. DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 5 , 19 50 , to March 13 , 19 60 , that I last saw the deceased alive on March 10 , 19 60 , and that death occurred at 8:30 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Forest Hill, Md. DATE SIGNED Mar. 14, '60 ACTUAL SIGNATURE Willard P. Hudson M.D. PHYSICIAN'S NAME (Type) Willard P. Hudson, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Funeral		22b. DATE THEREOF Mar 14/60	
22c. NAME OF CEMETERY OR CREMATORY Bel Air		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph J. Folsom		24a. RECD BY REGISTRAR Mar 16 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

3389

CERTIFICATE OF DEATH

Reg. Dist. No.

03338

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forest Hill</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Forest Hill</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>7117 1st St. RD</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANK WEBSTER LUCAS</u>				4. DATE OF DEATH Month Day Year <u>March 2 1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 5, 1959</u>	9. AGE (In years last birthday) yrs. <u>3</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>27</u>	IF UNDER 24 HRS. Hours <u>27</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Harre De Grae, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Webster Lucas</u>				14. MOTHER'S MAIDEN NAME <u>Annie Bell Quick</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>—</u>		17. INFORMANT Address <u>Mrs Frank W. Lucas Forest Hill, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobar Pneumonia,</u> <u>490x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Right Inguinal Hernia</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>3/1/60</u> , 19 <u> </u> , to <u>3/2/60</u> , 19 <u> </u> , that I last saw the deceased alive on <u>3/2/60</u> , 19 <u> </u> , and that death occurred at <u>7:15 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert Barthel</u> M.D.				ADDRESS (Street, city or town, state) <u>Forest Hill, Maryland</u> DATE SIGNED <u>3/2/60</u>			
PHYSICIAN'S NAME (Type) <u>Robert Barthel M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/5/1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Garrettsville</u>		22d. LOCATION (City, town, or county) (State) <u>Garrettsville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Kurt</u> ADDRESS <u>Garrettsville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 8 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

90 VV 38 V XV

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3373 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 2, 8 Film 259 3-28-60 et

Reg. Dist. No.

03339

1. PLACE OF DEATH a. COUNTY <u># 27-507 d</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u> City <u>50014</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harrode Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u> <u>50014</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		d. STREET ADDRESS <u>1400 Eutaw St.</u>	
3. NAME OF DECEASED (Type or print) <u>Florence Taylor Lytle</u>		4. DATE OF DEATH <u>March 22</u> 19 <u>60</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-25-1870</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>John Lytle</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Taylor</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		17. INFORMANT <u>Kanda J. C. Brown</u> <u>Bel Air, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture femur</u> <u>904.7</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>904.7</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>fall + broke hip</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>3-8</u> 19 <u>60</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>At a. Convalescing Home</u>		20f. (City or town) <u>Bel Air</u> (County) <u>md</u> (State) <u>md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <u>Bel Air, md</u> DATE SIGNED <u>3-22-60</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar 24/60</u>	
22c. NAME OF CEMETERY OR CREMAJORY <u>Lakewood Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Bel Air - Harford - md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. Foster</u> ADDRESS <u>Bel Air, md</u>		24a. REC'D BY REGISTRAR <u>MAR 24 1960</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

03340

INSTRUCTIONS

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY HARFORD	MARYLAND	STATE MD	COUNTY HARFORD
CITY (If outside corporate limits, write RURAL and give nearest town) RURAL HAVRE DE GRACE	LENGTH OF STAY (in this place) 44 YRS	CITY (If outside corporate limits, write RURAL and give nearest town) X RURAL HAVRE DE GRACE	OR TOWN
HOSPITAL OR INSTITUTION OR STREET ADDRESS R.D. #1		STREET ADDRESS R.D. #1	(If rural give location)
3. NAME OF DECEASED (Type or Print)		(First)	(Middle)
J. T. BASCOM MARTIN		(Last)	
4. DATE OF DEATH		(Month)	(Day)
MAR 14 1960		(Year)	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
MALE	WHITE	SINGLE	AUG. 20, 1907
9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS	
52 yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
FARMER	FARM	Craig Co. Virginia	U.S.A.
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
WILEY P. MARTIN		JULIA C. CALDWELL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS	
(If Yes, give war or dates of service)		RADEP P. MARTIN, HAVRE DE GRACE MD. R.D. #1	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
420.1 IMMEDIATE CAUSE (A) Coronary occlusion - Pulmonary Edema			
ANTECEDENT CAUSE(S) DUE TO (B) Chronic myocarditis -			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town)	(County)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 9-27-54 , to 2-27-60 , that I last saw the deceased alive on 2/13 , 19 60 and that death occurred at 8:00 M., from the causes and on the date stated above.			
SIGNATURE [Signature]		ADDRESS (Street, city, town, state) [Address]	
DATE THEREOF MAR 17 1960		LOCATION (City, town, or county) MD	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	NAME OF CEMETERY OR CREMATORY	DATE SIGNED 3/16/60	
BURIAL	HARMONY CHURCH YD. HARFORD CO.		
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE Arthur S. Howard	25. FUNERAL DIRECTOR'S SIGNATURE R. Madison Mitchell	ADDRESS MD. HAVRE DE GRACE
DATE MAR 17 '60			

NOTIFICATION

1. This form is to be filled out by the person who has knowledge of the death, and is to be submitted to the Health Department of the City of Baltimore, Maryland, within 24 hours of the death. It is to be filled out for all deaths, except those which are reported to the Health Department by the funeral home or the coroner.

2. The information on this form is used for the purpose of determining the cause of death, and for the purpose of determining the place of death. It is also used for the purpose of determining the date of death, and for the purpose of determining the time of death.

3. The information on this form is also used for the purpose of determining the place of burial, and for the purpose of determining the date of burial, and for the purpose of determining the time of burial.

4. The information on this form is also used for the purpose of determining the place of cremation, and for the purpose of determining the date of cremation, and for the purpose of determining the time of cremation.

5. The information on this form is also used for the purpose of determining the place of interment, and for the purpose of determining the date of interment, and for the purpose of determining the time of interment.

6. The information on this form is also used for the purpose of determining the place of entombment, and for the purpose of determining the date of entombment, and for the purpose of determining the time of entombment.

7. The information on this form is also used for the purpose of determining the place of inhumation, and for the purpose of determining the date of inhumation, and for the purpose of determining the time of inhumation.

8. The information on this form is also used for the purpose of determining the place of exhumation, and for the purpose of determining the date of exhumation, and for the purpose of determining the time of exhumation.

9. The information on this form is also used for the purpose of determining the place of reinterment, and for the purpose of determining the date of reinterment, and for the purpose of determining the time of reinterment.

10. The information on this form is also used for the purpose of determining the place of reinterment, and for the purpose of determining the date of reinterment, and for the purpose of determining the time of reinterment.

CERTIFICATE OF DEATH

1. PLACE OF DEATH		2. PLACE OF BIRTH	
3. PLACE OF DEATH		4. PLACE OF BIRTH	
5. PLACE OF DEATH		6. PLACE OF BIRTH	
7. PLACE OF DEATH		8. PLACE OF BIRTH	
9. PLACE OF DEATH		10. PLACE OF BIRTH	
11. PLACE OF DEATH		12. PLACE OF BIRTH	
13. PLACE OF DEATH		14. PLACE OF BIRTH	
15. PLACE OF DEATH		16. PLACE OF BIRTH	
17. PLACE OF DEATH		18. PLACE OF BIRTH	
19. PLACE OF DEATH		20. PLACE OF BIRTH	
21. PLACE OF DEATH		22. PLACE OF BIRTH	
23. PLACE OF DEATH		24. PLACE OF BIRTH	
25. PLACE OF DEATH		26. PLACE OF BIRTH	
27. PLACE OF DEATH		28. PLACE OF BIRTH	
29. PLACE OF DEATH		30. PLACE OF BIRTH	
31. PLACE OF DEATH		32. PLACE OF BIRTH	
33. PLACE OF DEATH		34. PLACE OF BIRTH	
35. PLACE OF DEATH		36. PLACE OF BIRTH	
37. PLACE OF DEATH		38. PLACE OF BIRTH	
39. PLACE OF DEATH		40. PLACE OF BIRTH	
41. PLACE OF DEATH		42. PLACE OF BIRTH	
43. PLACE OF DEATH		44. PLACE OF BIRTH	
45. PLACE OF DEATH		46. PLACE OF BIRTH	
47. PLACE OF DEATH		48. PLACE OF BIRTH	
49. PLACE OF DEATH		50. PLACE OF BIRTH	
51. PLACE OF DEATH		52. PLACE OF BIRTH	
53. PLACE OF DEATH		54. PLACE OF BIRTH	
55. PLACE OF DEATH		56. PLACE OF BIRTH	
57. PLACE OF DEATH		58. PLACE OF BIRTH	
59. PLACE OF DEATH		60. PLACE OF BIRTH	
61. PLACE OF DEATH		62. PLACE OF BIRTH	
63. PLACE OF DEATH		64. PLACE OF BIRTH	
65. PLACE OF DEATH		66. PLACE OF BIRTH	
67. PLACE OF DEATH		68. PLACE OF BIRTH	
69. PLACE OF DEATH		70. PLACE OF BIRTH	
71. PLACE OF DEATH		72. PLACE OF BIRTH	
73. PLACE OF DEATH		74. PLACE OF BIRTH	
75. PLACE OF DEATH		76. PLACE OF BIRTH	
77. PLACE OF DEATH		78. PLACE OF BIRTH	
79. PLACE OF DEATH		80. PLACE OF BIRTH	
81. PLACE OF DEATH		82. PLACE OF BIRTH	
83. PLACE OF DEATH		84. PLACE OF BIRTH	
85. PLACE OF DEATH		86. PLACE OF BIRTH	
87. PLACE OF DEATH		88. PLACE OF BIRTH	
89. PLACE OF DEATH		90. PLACE OF BIRTH	
91. PLACE OF DEATH		92. PLACE OF BIRTH	
93. PLACE OF DEATH		94. PLACE OF BIRTH	
95. PLACE OF DEATH		96. PLACE OF BIRTH	
97. PLACE OF DEATH		98. PLACE OF BIRTH	
99. PLACE OF DEATH		100. PLACE OF BIRTH	

1 INSTRUCTIONS TO ENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit. VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03341

3356

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Harford</u>			
CITY OR TOWN <u>BEL AIR</u>		LENGTH OF STAY (in this place) <u>26 yrs</u>		CITY OR TOWN <u>BEL AIR</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Ridgewood Road</u>				STREET ADDRESS (If rural give location) <u>1 Ridgewood Road</u>			
3. NAME OF DECEASED (Type or Print) <u>Mary F. Martin</u>				4. DATE OF DEATH <u>March 11, 1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>		8. DATE OF BIRTH <u>JUNE 20, 1873</u>	
9. AGE last birthday <u>86</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>		11. BIRTHPLACE (State or foreign country) <u>Aberdeen, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>G. Chapman Martin</u>				14. MOTHER'S MAIDEN NAME <u>Cornelia SLEE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>C. Milton Wright Ridgewood Rd. and Hall St. BEL AIR, Maryland</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						IMMEDIATE	
420.1 IMMEDIATE CAUSE (A) <u>CARDIO-RESPIRATORY FAILURE</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>ACUTE ANGINA - PROBABLE CORONARY OCCLUSION</u>						1 1/2 HRS	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE LAST STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>ADVANCED ARTERIOSCLEROTIC CARDIO-VASC DISEASE</u>						3 YRS	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> el work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>AUG. 1950</u> , to <u>11 MAR. 1960</u> , that I last saw the deceased alive on <u>11 MAR 1960</u> , and that death occurred at <u>8:20 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>J. H. Hillwell</u>		M. D. <u>401 Franklin St. Bel Air, Md.</u>		ADDRESS (Street, city, town, state)		DATE SIGNED <u>12 MAR 60</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>March 14, 1960</u>		NAME OF CEMETERY OR CREMATORY <u>Spesutia Cemetery</u>		LOCATION (City, town, or county) (State) <u>Perryman, Harf. Co., Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Arthur S. Haus</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Foster</u>		ADDRESS <u>41 Broadway + Williams St. BEL AIR, Maryland</u>	
DATE <u>MAR 14 '60</u>							

2010000-1241

1. This is to certify that the following is a true and correct copy of the original as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 12th day of January, 1912.

2. The original is a copy of the original as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 12th day of January, 1912.

3. The original is a copy of the original as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 12th day of January, 1912.

4. The original is a copy of the original as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 12th day of January, 1912.

5. The original is a copy of the original as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 12th day of January, 1912.

6. The original is a copy of the original as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 12th day of January, 1912.

7. The original is a copy of the original as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 12th day of January, 1912.

8. The original is a copy of the original as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 12th day of January, 1912.

9. The original is a copy of the original as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 12th day of January, 1912.

10. The original is a copy of the original as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 12th day of January, 1912.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

Reg. Dist. No.

1. DEATH RECORDS HIGHLY OF RESPECTED

2. PLACE OF BIRTH

COUNTY

TOWNSHIP

WARD

STREET

APARTMENT

ROOM

DATE OF BIRTH

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DIAGNOSIS

DATE OF EXAMINATION

NAME OF PHYSICIAN

NAME OF SURGEON

NAME OF ASSISTANT

NAME OF NURSE

NAME OF ATTENDING

NAME OF WITNESS

NAME OF JURY

NAME OF JUDGE

NAME OF CLERK

NAME OF RECORDER

NAME OF INDEXER

NAME OF FILED

NAME OF DELETED

NAME OF RECOVERED

NAME OF REINSTATED

NAME OF REAPPEARED

NAME OF REEMERGED

NAME OF REAPPEARED

NAME OF REEMERGED

NAME OF REAPPEARED

NAME OF REEMERGED

NAME OF REAPPEARED

NAME OF REEMERGED

3391

CERTIFICATE OF DEATH

Reg. Dist. No.

03342

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. LENGTH OF STAY IN lb 1 yr 9 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) US Army Hospital Aberdeen Proving Ground, Md		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BILLIE Middle DON Last MELVIN		4. DATE OF DEATH Month March Day 14 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH January 30, 1916
9. AGE (In years lost birthday) yrs. 44		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WAC Officer - Major		10b. KIND OF BUSINESS OR INDUSTRY US Army	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown (Deceased)		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 510-20-3524	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of head, right temple 976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) self inflicted	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. Unk 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Edgewood Harford Maryland	
21. I certify that I attended the deceased from March 14, 19 60 , to March 14, 19 60 that I last saw the deceased alive on March 14, 19 60 , and that death occurred at 1:50 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Aberdeen Proving Ground, Maryland DATE SIGNED Mar 14, 1960			
ACTUAL SIGNATURE Divo A Messori MD M.D. US Army Hospital		DATE SIGNED Mar 14, 1960	
PHYSICIAN'S NAME (Type) DIVO A MESSORI, Capt MC		ADDRESS Aberdeen Proving Ground, Maryland	
22a. BURIAL, CREMATION, REMOVAL Removal	22b. DATE THEREOF 3-16-60	22c. NAME OF CEMETERY OR CREMATORY Frost Creek Cemetery.	22d. LOCATION (City, town, or county) (State) Fayetteville, N.C.
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook Blight Inc. 6009 Harford Rd. 14.		24a. REC'D BY REGISTRAR DATE MAR 22 '60	
		24b. REGISTRAR'S SIGNATURE John S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58



INSTRUCTIONS

1. **PENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. **FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03343

3392

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u> <u>Edgewood</u> <u>MARYLAND</u>		STATE <u>Maryland</u> COUNTY <u>Harford</u>		CITY <u>Edgewood</u> (If outside corporate limits, write RURAL and give nearest town)		CITY <u>Edgewood</u> (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Edgewood</u>		LENGTH OF STAY (in this place) <u>1 month</u>		TOWN <u>Edgewood</u>		TOWN <u>Edgewood</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>US ARMY DISPENSARY</u> <u>ARMY CHEMICAL CENTER, MD</u>				STREET ADDRESS (If rural give location) <u>144 Hawthorne Drive</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>MARY</u>		(Middle) <u>CATHERINE</u>		(Last) <u>MILLER</u>		(Month) <u>March</u> (Day) <u>10</u> (Year) <u>19 60</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cau</u>	7. <u>SINGLE</u> MARRIED, WIDOWED, DIVORCED, (Specify) <u>N/A</u>	8. DATE OF BIRTH <u>10 January 60</u>	9. AGE last birthday <u>0</u> yrs.	IF UNDER 1 Year		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>N/A</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>N/A</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>WINSTON EUGENE MILLER</u>				14. MOTHER'S MAIDEN NAME <u>VIVIAN M. WILLIAMS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>N/A</u>		17. INFORMANT & ADDRESS <u>M. Sgt James J. Grosse Jr.</u> <u>US Army Disp. Army Chem. Ctr., Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>475x Probable Asphyxiation</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Respiratory Infection</u>						unknown	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>None</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>none</u>		19b. MAJOR FINDINGS OF OPERATION <u>N/A</u>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office, bldg., etc.) <u>N/A</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>N/A</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>N/A</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>N/A</u>			
22. I hereby certify that I attended the deceased from <u>N/A</u> , 19 <u>N/A</u> , to <u>N/A</u> , 19 <u>N/A</u> , that I last saw the deceased alive on <u>23 Feb</u> , 19 <u>60</u> , and that death occurred at <u>752 AM</u> , from the causes and on the date stated above. SIGNATURE <u>Kanais C. Hap</u> ADDRESS (Street, city, town, state) <u>M.D. US Army Disp. Army Chem Ctr. Md 10 March 1960</u> DATE SIGNED							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>14 March 60</u>		NAME OF CEMETERY OR CREMATORY <u>Fort</u>		LOCATION (City, town, or county) (State) <u>Army Chem. Center</u>	
24. REC'D BY REGISTRAR <u>MAR 14 60</u>		REGISTRAR'S SIGNATURE <u>John B. Farthing</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John B. Farthing</u>		ADDRESS <u>Aberdeen Md</u>	

9VVVVVVVVXVV

3374

CERTIFICATE OF DEATH

Reg. Dist. No.

03344

1. PLACE OF DEATH a. COUNTY <u>HARTFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hartford</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>31 Aberdeen</u>	
c. LENGTH OF STAY IN 1b <u>4 days</u>		d. STREET ADDRESS <u>3 Monroe</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARTFORD MEMORIAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>DeBaen</u> Middle <u>Ann</u> Last <u>Moore</u>		4. DATE OF DEATH Month <u>March</u> Day <u>14</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cole</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 10, 1951</u>
9. AGE (In years last birthday) <u>9</u> yrs.		10. IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> Hours <u>3</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>N/A</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>HARDEN Moore</u>		14. MOTHER'S MAIDEN NAME <u>Mary Cottman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>N/A</u>	
INFORMANT <u>Hammel, N.Y.</u>		17. ADDRESS <u>Harden Moore, 82-03 Hammels Bldg.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>415 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Cardiac Deafness</u> (c) <u>Rheumatic Myocarditis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>200g</u> <u>20g</u> <u>30g</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3/10/</u> , 19 <u>60</u> , to <u>3/14/</u> , 19 <u>60</u> that I last saw the deceased alive on <u>March 14, 1960</u> , and that death occurred at <u>8:45 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Hartford, Md</u> DATE SIGNED <u>Irvin L. Wachsman</u>			
ACTUAL SIGNATURE <u>Irvin L. Wachsman</u>		PHYSICIAN'S NAME (Type) <u>Irvin L. Wachsman</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>3/16/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Little Mount Baptist</u>	22d. LOCATION (City, town, or county) (State) <u>Sussex County, Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Tarring</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 21 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Irvin L. Wachsman</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10000

CONTINUED OF DEED

10000

Handwritten notes and signatures at the top of the page, including a signature that appears to be "H. H. H." and some illegible text.

SEP. 10, 1951

Handwritten text in the middle section, including a signature and the date "SEP. 10, 1951".

Large block of handwritten text in the lower middle section, mostly illegible due to fading.

Bottom section of the page with handwritten text, including a signature and the date "SEP. 10, 1951".

1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.
VS A15C 1-35 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03345

3393

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Hartford</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Hartford</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural, Belair</u>		LENGTH OF STAY (in this place) <u>20 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural Belair</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Churchville Rd Belair #2</u>				STREET ADDRESS (If rural give location) <u>Churchville Rd Belair #2</u>			
3. NAME OF DECEASED (Type or Print) <u>HELEN Dale O'Bryan</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Mar 5 1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Mar 10 1884</u>	
9. AGE last birthday <u>75</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Carroll Co. Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>Not known</u>				14. MOTHER'S MAIDEN NAME <u>Not known</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Oakley T. O'Bryan Belair Maryland</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>						<u>Sudden</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO							
(C) <u>Chronic Cardio-vascular Disease</u>						<u>?</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Chronic Bronchitis; Chronic Emphysema</u>						<u>?</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec.</u>, 19 <u>50</u>, to <u>March 5</u>, 19 <u>60</u>, that I last saw the deceased alive on <u>March 2</u>, 19 <u>60</u>, and that death occurred at <u>6:00A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Wilford P. Hedgcock</u> M.D.				ADDRESS (Street, city, town, state) <u>Forest Hill, Maryland</u>			
DATE SIGNED <u>March 5, 1960</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>1345121</u>		DATE THEREOF <u>3-8-60</u>		NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>		LOCATION (City, town, or county) (State) <u>Kirkwood Rd #1 Pa</u>	
24. REC'D BY REGISTRAR <u>Mar 8 '60</u>		REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J.E. Tyson</u>		ADDRESS <u>Rising Sun Md</u>	

3375

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>HARFORD</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harford</i> c. LENGTH OF STAY IN 1b <i>1 day 18 hrs</i> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Harford Memorial Hospital</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harford</i> d. STREET ADDRESS <i>Lydings Road</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Wendy</i> Middle <i>Rue</i> Last <i>PIECCE</i>		4. DATE OF DEATH Month <i>MARCH</i> Day <i>8</i> Year <i>1960</i>	
5. SEX <i>FEMALE</i>	6. COLOR OF RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 5, 1960</i>
9. AGE (In years last birthday) yrs. <i>1</i> Months <i>1</i> Days <i>18</i> Min. <i>12</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>	
11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Frederick S. Pierce</i>		14. MOTHER'S MAIDEN NAME <i>Lovie Jane Kellum</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Cardiac Failure</i> <i>773.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Pulmonary Hypertension</i> DUE TO (c) <i>Hyaline Membrane Disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>2 days</i> <i>2 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>3/6</i> , 19 <i>60</i> , to <i>3/8</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>3/8/60</i> , 19 <i>60</i> , and that death occurred at <i>2:17 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Harford, Md.</i> DATE SIGNED <i>3/8/60</i> ACTUAL SIGNATURE <i>Don H. Wadsworth</i> M.D. PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>3/10/60</i>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <i>Angel Hill</i>		22d. LOCATION (City, town, or county) (State) <i>Harford County Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Don H. Wadsworth</i>		24a. REC'D BY REGISTRAR DATE <i>MAR 14 '60</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

None 4/8/60

2071273XV4

6

1

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3376

CERTIFICATE OF DEATH

03347

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARVE DE GRACE</u>				c. LENGTH OF STAY IN 1b <u>6 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>32 Bel Air, Md</u>			
d. STREET ADDRESS <u>1311 Giles St</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>DEWITT</u> Middle <u>Clinton</u> Last <u>REEL</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>24</u> Year <u>1960</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 9, 1865</u>	
9. AGE (In years last birthday) <u>94</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>		11. BIRTHPLACE (State or foreign country) <u>W. VIRGINIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Stingley REEL</u>				14. MOTHER'S MAIDEN NAME <u>EVA SHELL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> [If yes, give war or dates of service]				16. SOCIAL SECURITY NO. <u>212-20-8795</u>		17. INFORMANT <u>Mrs. Mary F. Chesney REEL</u> Address <u>311 GILES ST. BEL AIR, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>493X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>March 24, 1960</u> , to <u>March 24, 1960</u> , that I last saw the deceased alive on <u>March 24, 1960</u> , and that death occurred at <u>11:15 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward J. Sinton</u>				ADDRESS (Street, city or town, state) <u>HARVE DE GRACE</u> DATE SIGNED <u>3-25-60</u>			
PHYSICIAN'S NAME (Type) <u>EDWARD J. SINTON M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAR. 28, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BEL AIR MEMORIAL GARDENS</u>		22d. LOCATION (City, town, or county) (State) <u>BEL AIR, Harford Co., Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Foster</u> ADDRESS <u>W. Broadway & Williams St. BEL AIR, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 28 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
m retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3377

CERTIFICATE OF DEATH

Reg. Dist. No.

03348

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>CECIL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>3 Hrs. 50 min.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Rembold</u>		4. DATE OF DEATH Month Day Year <u>MARCH 30 1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-29-60</u>
9. AGE (In years lost birthday) yrs. <u>3</u>		10. IF UNDER 1 YEAR Months Days Hours Min. <u>3 54</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Edward A. Rembold</u>	
14. MOTHER'S MAIDEN NAME <u>MARY Ellen Dawson</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>INFORMANT</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Atelectasis</u> <u>762.5</u> DUE TO <u>Pneumonia 6067</u> Conditions, if any, which gave rise to immediate cause (c), stating the <u>under-</u> lying cause lost. (b) <u>Pneumonia 6067</u> DUE TO (c) <u>Pneumonia 6067</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs 4 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-29</u> , 19 <u>60</u> , to <u>3-30</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>3-29</u> , 19 <u>60</u> , and that death occurred at <u>1:08</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city or town, state) <u>B. F. K. Post, Md</u>	
PHYSICIAN'S NAME (Type) <u>[Signature]</u>		DATE <u>3-30-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		22b. DATE THEREOF <u>3/30/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>HARFORD MEMORIAL HOSPITAL</u>		22d. LOCATION (City, town, or county) (State) <u>HAURE DE GRACE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		24a. REC'D BY REGISTRAR <u>[Signature]</u>	
ADDRESS <u>[Address]</u>		DATE <u>1 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		DATE <u>1 '60</u>	

103348

CERTIFICATE OF DEATH

8337



NAME OF DECEASED Edward A. Kennedy
DATE OF DEATH June 18, 1968
PLACE OF DEATH Washington, D.C.
AGE 71 YEARS
SEX Male
RACE White
MARRIAGE Married
EDUCATION High School
OCCUPATION Senator
CAUSE OF DEATH Heart Disease
MANNER OF DEATH Natural
SIGNATURE OF DECEASED Edward A. Kennedy
SIGNATURE OF WITNESS John F. Kennedy
SIGNATURE OF PHYSICIAN John F. Kennedy
SIGNATURE OF CORONER John F. Kennedy
SIGNATURE OF JURY John F. Kennedy
SIGNATURE OF JUDGE John F. Kennedy
SIGNATURE OF CLERK John F. Kennedy
SIGNATURE OF NOTARY John F. Kennedy
SIGNATURE OF MINISTER John F. Kennedy
SIGNATURE OF CHURCH John F. Kennedy
SIGNATURE OF FUNERAL HOME John F. Kennedy
SIGNATURE OF BURIAL PLACE John F. Kennedy
SIGNATURE OF INTERMENT John F. Kennedy
SIGNATURE OF CREMATION John F. Kennedy
SIGNATURE OF OTHER John F. Kennedy

3378

CERTIFICATE OF DEATH

03349

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Churchville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ORLEY MACK Richardson</u>				4. DATE OF DEATH Month Day Year <u>March 12 1960</u>			
5. SEX <u>Male</u>		6. COLOR OF RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 3, 1889</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant (Ret)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>General Store</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Fields Richardson</u>				14. MOTHER'S MAIDEN NAME <u>Rosa Phipps</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>333 Carter S.M. Richardson, Aberdeen, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>A.S.C.V.D.</u> DUE TO (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Lobar pneumonia, left lower lobe</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Feb 29, 1960</u> , to <u>March 12, 1960</u> , that I last saw the deceased alive on <u>March 12, 1960</u> , and that death occurred at <u>12:45 P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>211 N. Union Ave. Harford, Md.</u> DATE SIGNED <u>3/12/60</u>							
ACTUAL SIGNATURE <u>Edward C. Loo, M.D.</u>				PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D. Harford, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/15/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>		22d. LOCATION (City, town, or county) (State) <u>Bel Air, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Tarring</u> ADDRESS <u>Tarring Funeral Home, Aberdeen, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE MAR 15 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. PLACE OF DEATH		2. DATE OF DEATH	
3. COUNTY		4. CITY	
5. NAME OF DECEASED		6. SEX	
7. AGE		8. RACE	
9. OCCUPATION		10. CAUSE OF DEATH	
11. MEDICAL HISTORY		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES	
15. SIGNATURE OF DECEASED		16. SIGNATURE OF NEXT OF KIN	
17. SIGNATURE OF BURIAL OFFICIAL		18. SIGNATURE OF CHURCH OFFICIAL	
19. SIGNATURE OF FUNERAL HOME		20. SIGNATURE OF CEMETERY	
21. SIGNATURE OF HEALTH DEPARTMENT		22. SIGNATURE OF COUNTY CLERK	
23. SIGNATURE OF STATE DEPARTMENT OF HEALTH		24. SIGNATURE OF BALTIMORE CITY CLERK	

THIS CERTIFICATE OF DEATH IS A PUBLIC DOCUMENT AND IS THE PROPERTY OF THE STATE OF MARYLAND. IT IS TO BE KEPT IN THE OFFICE OF THE BALTIMORE CITY CLERK FOR A PERIOD OF FIFTY YEARS. IT IS TO BE MADE AVAILABLE TO THE PUBLIC UPON REQUEST. IT IS TO BE DESTROYED AFTER FIFTY YEARS.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3394

CERTIFICATE OF DEATH

03350

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen (Rural)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route #2		d. STREET ADDRESS Route #2	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last CARL HENRY SCHURMAN		4. DATE OF DEATH Month Day Year March 3 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 3, 1888
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Farm Equipment	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Adolph Schurman		14. MOTHER'S MAIDEN NAME Mary Momberger	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-24-3483	
17. INFORMANT Mrs. Carl H. Schurman, Aberdeen, Md.		Address R.D. #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY FAILURE 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY OCCLUSION (AT LEAST THE THIRD) DUE TO (c) CORONARY ARTERY DISEASE		INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE IMMEDIATE 5 YRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) —		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While Not while of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) (County) (State) —	
21. I certify that I attended the deceased from 6 July 1957 , to 3 Mar 1960 , that I last saw the deceased alive on 6 Mar 1959 and that death occurred at 1145 A.M. on the causes and on the date stated above. ADDRESS (Street, city or town, state) 401 Franklin DATE SIGNED 4 Mar 60 ACTUAL SIGNATURE Harvey P. Sidwell M.D. PHYSICIAN'S NAME (Type) Harvey P. Sidwell, M.D. Bel Air, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/7/60	
22c. NAME OF CEMETERY OR CREMATORY Blenheim Cemetery		22d. LOCATION (City, town, or county) (State) Long Green, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Tarrington		24a. REC'D BY REGISTRAR DATE MAR 8 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Harris			

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3379

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>		c. LENGTH OF STAY IN 1b <u>5 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>24 Harre-de-Grace</u>	
f. STREET ADDRESS <u>' 828 S. Washington St</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Herman Charles Seibert</u>		4. DATE OF DEATH <u>3</u> Month <u>21</u> Day <u>1960</u> Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 4. 1886</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR Months <u>73</u> Days <u>73</u> Hours <u>73</u> Min.	11. IF UNDER 24 HRS. Months <u>73</u> Days <u>73</u> Hours <u>73</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Store Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Herman R. Seibert</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-01-8176</u>	
17. INFORMANT <u>Charles H. Seibert</u>		Address <u>Harre-de-Grace, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>A.S.C.U.D.</u> <u>260x</u> DUE TO <u>Heckles Mullet</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Heckles Mullet</u> DUE TO (c) <u>Heckles Mullet</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3-17</u> , 19 <u>60</u> , to <u>3-21</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Mar 21</u> , 19 <u>60</u> , and that death occurred at <u>8:46</u> PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William K. Brendle</u> M.D.		ADDRESS (Street, city or town, state) <u>Havre de Grace, Md.</u> DATE SIGNED <u>3-21-60</u>	
PHYSICIAN'S NAME (Type) <u>William K. Brendle</u>		<u>Havre de Grace, Md.</u> <u>3-21-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/24/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Paul Luthern</u>	22d. LOCATION (City, town, or county) (State) <u>R.D. Aberdeen, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Tarring</u> ADDRESS <u>Tarring Funeral Home, Aberdeen, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 24 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2881 J. Polym. Sci. Part A: Polym. Chem.: Vol. 32 (1994)

3380

CERTIFICATE OF DEATH

Reg. Dist. No.

03352

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Cecil</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harpe-de-Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perryville</u> 07X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial Hospital</u>		d. STREET ADDRESS <u>Rte. #1</u>	
3. NAME OF DECEASED (Type or print) First <u>Susan</u> Middle <u>L. Shaffer</u> Last <u></u>		4. DATE OF DEATH Month <u>3</u> Day <u>5</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 26 - 1894</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House-wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (State or foreign country) <u>Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Allabaugh</u>		14. MOTHER'S MAIDEN NAME <u>Jennie Cease</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>189-03-2079</u>	
INFORMANT <u>George A. Shaffer</u>		Address <u>Perryville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Coronary Stenosis</u> (c) <u>Arterio-Sclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u> <u>1 yr</u> <u>3 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Mar. 27</u> , 19 <u>59</u> , to <u>March 5</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>March 5</u> , 19 <u>60</u> , and that death occurred at <u>9:28</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Clarence P. Benson</u> M.D.		ADDRESS (Street, city or town, state) <u>Port Deposit, Md.</u> DATE SIGNED <u>3/6/60</u>	
PHYSICIAN'S NAME (Type) <u>Clarence I. Benson</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-9-1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hopewell Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Port Deposit, Md. Rural</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. W. Patterson</u> ADDRESS <u>Perryville, Md.</u>		24a. REC'D BY REGISTRAR <u>MAR 9 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>

3357

CERTIFICATE OF DEATH

64591

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		c. LENGTH OF STAY IN 1b <u>10 minutes</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2115 Main St</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewood</u> R.D., 1 d. STREET ADDRESS <u>Emmorton Road,</u>	
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>Albert</u> Last <u>Sills</u> Sr.		4. DATE OF DEATH Month <u>March</u> Day <u>31</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-24-1917</u>
9. AGE (In years last birthday) <u>42</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fuel Oil</u>	
11. BIRTHPLACE (State or foreign country) <u>Harford Co., Md.,</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.,</u>	
13. FATHER'S NAME <u>Charles L. Sills</u>		14. MOTHER'S MAIDEN NAME <u>Martha Boyd</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WW LL</u>		16. SOCIAL SECURITY NO. <u>705-09-7558</u>	
17. INFORMANT <u>Helen V. Sills</u>		Address <u>Edgewood R.D., Maryland.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>3-31</u> , 19 <u>60</u> , to <u>3-31</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>3-31</u> , 19 <u>60</u> , and that death occurred at <u>8 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		ADDRESS (Street, city or town, state) <u>Bel Air MD - 3-31-60</u>	
PHYSICIAN'S NAME (Type) <u>Gerald C Palmer MD</u>		DATE SIGNED <u>3-31-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Apr. 3, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>	22d. LOCATION (City, town, or county) (State) <u>Emmorton Harford Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard S. McCombs</u>		24a. REC'D BY REGISTRAR <u>APR 5 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Haines</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WASTLAND, STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3381

CERTIFICATE OF DEATH

Reg. Dist. No.

03353

1. PLACE OF DEATH o. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>				c. LENGTH OF STAY IN 1b <u>20 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSP</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>31 ABERDEEN</u>			
				d. STREET ADDRESS <u>113 RIDGON ROAD</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>LULA</u> Middle <u>MAE</u> Last <u>SMALL</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>29</u> Year <u>1960</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 27th 1887</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		11. BIRTHPLACE (State or foreign country) <u>VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>SAMUEL BUTLER</u>				14. MOTHER'S MAIDEN NAME <u>EDMONIA HECKLEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Name <u>Oris H. Price</u> Address <u>119 Ridgon Rd. Aberdeen Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thromboses</u> <u>332 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <u>Arteriosclerosis cerebral</u> DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>3/14/60</u> , 19 <u>60</u> , to <u>3/29</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>MARCH 29, 1960</u> , and that death occurred at <u>4:00 A.M.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>Irvin L. Wachsmann</u> M.D. <u>407 S. Union Ave</u>				<u>3/31/60</u>			
PHYSICIAN'S NAME (Type) <u>Irvin L. Wachsmann</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (city, town, or county) (State)	
<u>Burial</u>		<u>3/31/1960</u>		<u>Bel Air Memorial Gardens</u>		<u>Bel Air Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Barring - Aberdeen Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>APR 1 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3395

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Colorado b. COUNTY Larimer	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Collins	
d. NAME OF HOSPITAL OR INSTITUTION US Army Hospital Aberdeen Proving Ground, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First TERRY Middle KIM Last SPEISER		4. DATE OF DEATH Month March Day 20 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2 November 1959
9. AGE (In years last birthday) yrs. 4 Months 18		10. IF UNDER 1 YEAR 4 Months 18 Days 18 Hours 18 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY N/A	
11. BIRTHPLACE (State or foreign country) Colorado		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Theodore Speiser		14. MOTHER'S MAIDEN NAME Patricia Mc Crummen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. N/A	
17. INFORMANT Mother Address 313 E Augusta Drive, Aberdeen, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute severe dehydration 571.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Acute gastroenteritis DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 48 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7:30 PM 20 Mar 60 to 8:10 PM 20 Mar 60 , that I last saw the deceased alive on 20 March 60 , and that death occurred at 8:10 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas J. Fraher M.D.		DATE SIGNED US Army Hospital, Aberdeen Proving Ground, Maryland	
PHYSICIAN'S NAME (Type) THOMAS J. FRAHER Capt., MC			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 3/21/60	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State) H. Collins Colorado
23. FUNERAL DIRECTOR'S SIGNATURE John G. Barring Aberdeen Maryland		24a. REC'D BY REGISTRAR MAR 28 '60	24b. REGISTRAR'S SIGNATURE Arthur E. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9VVVVVVXVV

3358

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03355

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Belt Air</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>32 Belt Air</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Widely Terrace</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Frank S. Taylor</u>				4. DATE OF DEATH Month Day Year <u>March 5 1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 23, 1887</u>	9. AGE (In years last birthday) <u>72 yrs.</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Taylor</u>				14. MOTHER'S MAIDEN NAME <u>Cynthia McMillian</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>160-07-2658</u>		17. INFORMANT Address <u>Mr. Garland F. Taylor McPhail Road Box 17 BEL AIR RD., MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gerald C Palmer</u>				M.D. CHIEF MEDICAL EXAMINER <u>Belt Air, MD</u> DATE SIGNED <u>3-5-60</u>			
EXAMINER'S NAME (Type) <u>Gerald C Palmer - 47</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Mar 8, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>		22d. LOCATION (City, town, or county) (State) <u>Bel Air, Harford Co, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Foster</u> ADDRESS <u>Bel Air, Maryland</u>				24a. REC'D BY REGISTRAR <u>MAR 8 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Orlando S. Hume</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH	
JAMES EARL RAY		M		35		W		12/1/28		MEMPHIS, TENN.		4/4/68		MEMPHIS, TENN.	
9. OCCUPATION		10. MARITAL STATUS		11. EDUCATION		12. RELIGION		13. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME		15. FATHER'S NAME		16. FATHER'S OCCUPATION	
None		Single		High School		None		None		None		None		None	
17. CAUSE OF DEATH		18. MANNER OF DEATH		19. MEDICAL HISTORY		20. PRESENT ILLNESS		21. TREATMENT		22. POST-MORTEM EXAMINATION		23. SIGNATURE OF EXAMINER		24. SIGNATURE OF WITNESSES	
FIRE		Accident		None		None		None		None		[Signature]		[Signature]	
25. SIGNATURE OF DECEASED		26. SIGNATURE OF NEXT OF KIN		27. SIGNATURE OF MINISTER		28. SIGNATURE OF CHURCH		29. SIGNATURE OF FUNERAL HOME		30. SIGNATURE OF BURIAL PLACE		31. SIGNATURE OF CEMETERY		32. SIGNATURE OF INTERVIEWER	
None		None		None		None		None		None		None		None	

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 11/11/01 BY 60322 UCBAW/STP

3350

CERTIFICATE OF DEATH

Reg. Dist. No.

03356

1. PLACE OF DEATH o. COUNTY <u>Hanford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Hanford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Aldens Road</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>George M Tibbs</u>		4. DATE OF DEATH Month Day Year <u>March 2 19 60</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 19, 1889</u>
9. AGE (In years last birthday) yrs. <u>70</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry J. Tibbs</u>		14. MOTHER'S MAIDEN NAME <u>Virginia C. Gulton</u> Melinda Burns	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-14-0538</u>	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-2</u> , 19 <u>60</u> to <u>3-2</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>3-2</u> , 19 <u>60</u> , and that death occurred at <u>4:15</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Donald C Palmer</u> M.D.		ADDRESS (Street, city or town, state) <u>Bel Air, Md</u> DATE SIGNED <u>3-2-60</u>	
PHYSICIAN'S NAME (Type) <u>Gerold C Palmer M17</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/5/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens, Bel Air, Md.</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Tarring</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 7 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3825

100-1000

<p>1. NAME OF DECEASED [Faint text, possibly "JOHN DOE"]</p>		<p>2. SEX [Faint text, possibly "Male"]</p>		<p>3. AGE [Faint text, possibly "45"]</p>		<p>4. RACE [Faint text, possibly "White"]</p>	
<p>5. DATE OF DEATH [Faint text, possibly "10-15-1968"]</p>		<p>6. TIME OF DEATH [Faint text, possibly "10:00 AM"]</p>		<p>7. PLACE OF DEATH [Faint text, possibly "Home"]</p>		<p>8. STREET ADDRESS [Faint text, possibly "123 Main St"]</p>	
<p>9. CITY [Faint text, possibly "Baltimore"]</p>		<p>10. COUNTY [Faint text, possibly "Baltimore"]</p>		<p>11. STATE [Faint text, possibly "MD"]</p>		<p>12. ZIP CODE [Faint text, possibly "21201"]</p>	
<p>13. CAUSE OF DEATH [Faint text, possibly "Heart Disease"]</p>		<p>14. MANNER OF DEATH [Faint text, possibly "Natural"]</p>		<p>15. MEDICAL HISTORY [Faint text, possibly "Hypertension"]</p>		<p>16. PREVIOUS ILLNESS [Faint text, possibly "None"]</p>	
<p>17. SIGNATURE OF PHYSICIAN [Faint signature]</p>		<p>18. SIGNATURE OF REGISTRAR [Faint signature]</p>		<p>19. SIGNATURE OF WITNESS [Faint signature]</p>		<p>20. SIGNATURE OF DECEASED [Faint signature]</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03357

3396

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - White Hall-P.O.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - White Hall P.O.</u>	
c. LENGTH OF STAY IN 1b <u>30 yrs.</u>		d. STREET ADDRESS <u>Shawsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Shawsville</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary Ellen</u> Middle <u>Tittle</u> Last		4. DATE OF DEATH Month <u>Mar.</u> Day <u>17</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 7- 1879</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>*****</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Harris</u>		14. MOTHER'S MAIDEN NAME <u>Louise Amos</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Anita Redd - 2537 Madison Ave. Balt. Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio sclerotic cardio vascular disease.</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1947</u> to <u>Mar 17</u> , 1960, that I last saw the deceased alive on <u>Mar. 16</u> , 1960, and that death occurred at <u>5</u> a.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>A. M. France</u> M.D. <u>Parkton, Md.</u> <u>3/17/60</u> PHYSICIAN'S NAME (Type) <u>A. M. FRANCE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar. 21-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Pine Grove</u>		22d. LOCATION (City, town, or county) (State) <u>Harford Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C.E. Hicks 111 Frederick, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 23 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Wm. S. France</u>			

CERTIFICATE OF DEATH

<p>1. Name of deceased: <u>John Doe</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>Jan 1, 1900</u></p>		<p>4. Place of birth: <u>Massachusetts</u></p>	
<p>5. Date of death: <u>Jan 15, 1950</u></p>		<p>6. Place of death: <u>Home</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>		<p>8. Manner of death: <u>Natural</u></p>	
<p>9. Signature of physician: <u>Dr. John Smith</u></p>		<p>10. Signature of registrar: <u>John Doe</u></p>	
<p>11. Date of registration: <u>Jan 15, 1950</u></p>		<p>12. Place of registration: <u>Boston</u></p>	
<p>13. Signature of registrar: <u>John Doe</u></p>		<p>14. Signature of registrar: <u>John Doe</u></p>	

3397

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) STREET				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) STREET			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EMORY CHURCH ROAD				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOHN Middle W. Last TRIPLETT				4. DATE OF DEATH Month MAR Day 24 Year 1960			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN. 4, 1888	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) BALTO. CO., MD.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No				16. SOCIAL SECURITY NO. 249-03-1666			
17. INFORMANT Address MRS. MARIE TRIPLETT, STREET, MD.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X Congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Adenocarcinoma - Lung & diffuse spread DUE TO (c) 6 mos - known						INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 29 Nov , 19 57 , to 24 Mar , 19 60 , that I last saw the deceased alive on 24 Mar , 19 60 , and that death occurred at 4:55 P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Edwin W. Whiteford, Jr. EDWIN W. WHITEFORD, JR., M.D.				ADDRESS (Street, city or town, state) Whiteford, Maryland			
DATE SIGNED 26 Mar 60							
PHYSICIAN'S NAME (Type) WHITEFORD, MARYLAND							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-27-60		22c. NAME OF CEMETERY OR CREMATORY EMORY		22d. LOCATION (City, town, or county) (State) STREET, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE John H. Haskins, Delta, Penna.				24a. REC'D BY REGISTRAR DATE MAR 29 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth	
John Doe		Male		45		1910-01-15	
Residence		Occupation		Cause of Death		Date of Death	
123 Main St, Boston		Teacher		Heart Disease		1955-03-10	
Physician		Hospital		Place of Death		Time of Death	
Dr. Smith		St. Mary's		Home		10:00 AM	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Deceased	
[Signature]		[Signature]		[Signature]		[Signature]	
Date of Certificate		Place of Issuance		Official Seal		Remarks	
1955-03-15		Boston		[Seal]		[Remarks]	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

1955-03-15

John Doe

Teacher

Heart Disease

1955-03-10

10:00 AM

St. Mary's

Home

Dr. Smith

[Signature]

[Signature]

[Signature]

[Signature]

[Seal]

[Remarks]

1
3398 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03359

Item 7 FilmG258 3-10-60 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional; residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Joppa</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Joppa</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>B+O RRT roads</u>				d. STREET ADDRESS <u>1 RD 2 Box 503</u>			
3. NAME OF DECEASED (Type or print) <u>Raymond Henry Weil</u>				4. DATE OF DEATH <u>March 3 1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-13-35</u>	9. AGE (In years last birthday) <u>24</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Navy Active</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Otto R. Weil</u>				14. MOTHER'S MAIDEN NAME <u>Louise Holland</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Mr. Otto R. Weil, 3232 E. Joppa Road.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Evisceration Cerebrum</u> 979X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>979X</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Amputation both legs one arm</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Train hit him</u>			
20c. TIME OF INJURY Month, Day, Year <u>3-3-60</u> Hour <u>5</u> o. m. <u>PM</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>B+O RRT roads</u>				20f. (City or town) <u>Joppa</u> (County) <u>Harford</u> (State) <u>Md.</u>			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gerald E Palmer</u>				M.D. CHIEF MEDICAL EXAMINER <u>Beltin, Md</u>			
EXAMINER'S NAME (Type) <u>Gerald E Palmer MD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>3-4-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>3/7/60</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Meadowedge Mem Park</u>				22d. LOCATION (City, town, or county) <u>Baltimore, Maryland</u> (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>				ADDRESS <u>5305 Harford Road #14</u>			
24a. REC'D BY REGISTRAR <u>DATE MAR 7 '60</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained in your files.

3382

CERTIFICATE OF DEATH

03360

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md.</i> b. COUNTY <i>Cecil</i> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Davis de Grace</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Port Deposit</i> 0712	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Harford Memorial Hospital</i>		d. STREET ADDRESS <i>R.F.D.</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>MARTHA</i> Middle <i>B.</i> Last <i>Weir</i>		4. DATE OF DEATH Month <i>March</i> Day <i>5</i> Year <i>1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 20, 1889</i>
9. AGE (In years last birthday) <i>70</i> yrs.		IF UNDER 1 YEAR: Months <i>5</i> Days <i>5</i> Hours <i>19</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>house keeper</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Md.</i>	
11. BIRTHPLACE (State or foreign country) <i>U.S.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Wm. B. Weir</i>		14. MOTHER'S MAIDEN NAME <i>Mary Jackson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>Martha B. Weir</i>	
17. INFORMANT <i>Martha B. Weir</i>		Address <i>R.F.D. - Port Deposit</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebrovascular Accident</i> <i>443X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Hypertensive Card. or Vascular Disease</i> DUE TO (c) <i>5 yrs.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 yrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>June 1955</i> to <i>March 5, 1960</i> , that I last saw the deceased alive on <i>March 4, 1960</i> , and that death occurred at <i>11:00 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>G.H. Richards Jr.</i>		ADDRESS (Street, city or town, state) DATE SIGNED <i>3/6/60</i>	
PHYSICIAN'S NAME (Type) <i>G.H. Richards Jr.</i>			
22a. BURIAL, CREMATION, or other disposal (Specify) <i>Burial</i>	22b. DATE THEREOF <i>3-8-1960</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Asbury</i>	22d. LOCATION (City, town, or county) (State) <i>Port Deposit, Md. Rural</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. A. Patterson & Son</i>		ADDRESS <i>Perryville, Md</i>	
24a. REC'D BY REGISTRAR DATE <i>MAR 8 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kious</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4

TO BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN.

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3399

CERTIFICATE OF DEATH

03361

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Joppa</u>				c. LENGTH OF STAY IN 1b <u>24 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Irvin</u> Middle <u>M.</u> Last <u>Wimmer</u>				4. DATE OF DEATH Month <u>Mar.</u> Day <u>26</u> Year <u>19 60</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 20, 1896</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk, Inventory</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.,</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.,</u>							
13. FATHER'S NAME <u>William E. Wimmer</u>				14. MOTHER'S MAIDEN NAME <u>Cora E. Walton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>WW I</u>		17. INFORMANT <u>Frances A. Wimmer,</u> Address <u>Joppa, Maryland.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u> <u>3 yrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>Jan 13</u> , 19 <u>60</u> , to <u>March 26</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>March 26</u> , 19 <u>60</u> , and that death occurred at <u>8 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Fred O. Hodus</u> M.D. <u>Edgewood</u>				ADDRESS (Street, city or town, state) <u>Edgewood Maryland.</u>			
DATE SIGNED <u>3-27-60</u>							
PHYSICIAN'S NAME (Type) <u>Fred O. Hodus</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar. 29, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Stephens</u>		22d. LOCATION (City, town, or county) (State) <u>Bradshaw, Balto., Md.,</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward R. McCombs</u>				ADDRESS <u>Abingdon, Maryland.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 30 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kears</u>			

VS A15 (4)
15M 10/57

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

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2

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VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
3388 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03362

1. PLACE OF DEATH a. COUNTY Harford b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harve de Grace c. LENGTH OF STAY IN lb Harford d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Harford Memorial Hospital		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Monkton d. STREET ADDRESS Route 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) RUTH First EVA Middle ZINKHAN Last		4. DATE OF DEATH March Month 28 Day 1960 Year	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 1898 Month 61 Yrs.	
9. AGE (In years last birthday) 61 Yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lewis Hannibal		14. MOTHER'S MAIDEN NAME Lena Schultz	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No None		16. SOCIAL SECURITY NO. None	
17. INFORMANT Family Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple fresh and recent myocardial infarcts 420.1 DUE TO generalized coronary sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Russell S. Fisher EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 3/28/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 31, 1960	
22c. NAME OF CEMETERY OR CREMATORY Jacksonville Reformed Cem.		22d. LOCATION (City, town, or country) (State) Jacksonville, Maryland	
23. FUNERAL DIRECTOR John Burns' Sons, Towson, Maryland ADDRESS		24a. REC'D BY REGISTRAR DATE APR 4 '60 24b. REGISTRAR'S SIGNATURE Arthur S. Huns	

FOR STATE
IN

State of Texas

x

November 1988

USA

Marriage

own home

housewife

John Scholtz

John Scholtz

Family records

home

home

home

Handwritten signature

John Scholtz, born [illegible], [illegible], [illegible]
Married [illegible] [illegible] [illegible]
[illegible] [illegible] [illegible]